

# **BOON-CHAPMAN**

## **SECTION 125 FLEX**

### **HEALTH CARE REIMBURSEMENT REQUEST FORM**

Mail, Fax or e-mail claim forms to:

**Boon-Chapman**  
P.O. Box 9201  
Austin, TX 78766  
(800) 252-9653 Phone  
(512) 459-1552 Fax  
flex@boonchapman.com

### **A. INSTRUCTIONS**

- COMPLETE ALL SECTIONS (B,C, AND D) FOR CHARGES TO BE CONSIDERED FOR REIMBURSEMENT.
- IF EXPENSE IS COVERED BY INSURANCE, SUBMIT TO APPROPRIATE CARRIER.
- ATTACH EXPLANATION OF BENEFITS (EOB) FROM THE INSURANCE CARRIER OR CO-PAY RECEIPTS.
- IF YOU ARE SUBMITTING AN ITEMIZED BILL ONLY, INDICATE WHY THIS BILL HAS NOT BEEN PAID BY YOUR INSURANCE PLAN
- ITEMIZED BILLS SHOULD INCLUDE THE FOLLOWING:  
\* PROVIDER NAME & ADDRESS \* PATIENT NAME \* ITEMIZED CHARGES \* DATE OF SERVICE \* TYPE OF SERVICE
- CANCELLED CHECKS, NON-ITEMIZED RECEIPTS AND BALANCE DUES ARE **NOT ACCEPTABLE** PROOF OF EXPENSES.

### **B. EMPLOYEE INFORMATION**

EMPLOYEE SOCIAL SECURITY #	COMPANY NAME	NEW ADDRESS (CIRCLE ONE) YES NO	PLAN YEAR
LAST NAME	FIRST NAME	EMAIL ADDRESS	
ADDRESS	CITY	STATE	ZIP CODE

### **C. HEALTH CARE EXPENSES**

PLEASE INDICATE IF YOU HAVE THE FOLLOWING TYPES OF COVERAGE: (CIRCLE ONE)

DENTAL COVERAGE?	YES	NO
MEDICAL COVERAGE?	YES	NO
VISION COVERAGE?	YES	NO

**\*IF YES, PLEASE BE SURE TO PROVIDE AN EXPLANATION OF BENEFITS (EOB) OR CO-PAYMENT RECEIPT.**

PATIENT NAME	RELATIONSHIP	TYPE OF SERVICE PROVIDED	DATE OF SERVICE	REIMBURSEMENT REQUEST AMOUNT
			<b>Total</b>	

### **D. CERTIFICATION**

I CERTIFY THAT THE EXPENSES FOR WHICH I AM REQUESTING REIMBURSEMENT MEET ALL OF THE FOLLOWING CONDITIONS:

- They were incurred for services or supplies by me or my eligible dependents under the plan.
- They were for services or supplies furnished on or after the effective date of my employee spending account.
- I have not been reimbursed for these expenses in any other way.

I understand that reimbursement of these expenses should be requested and made only after I have collected all benefit payments available from all plans under which my eligible dependents and I are covered. I further certify that I have not deducted or will not deduct on my individual income tax return any of the expenses reimbursed through my Health Care Spending Account. I understand that reimbursement will be made in accordance with the provisions of the plan. I accept responsibility for the proper treatment of benefits paid under this plan with respect to eligibility, income tax reporting, and liability.

EMPLOYEE SIGNATURE (REQUIRED)	DATE
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